DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 1 5

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 28, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440100(a)

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $0
b. FFY 03 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3. 1-A, pp. 40-40e; p. 47
Att. 3.1-B, pp. 39-39e; p. 46

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 3.1-A, pp. 40-40c; p 47
Att. 3.1-B, pp. 39-39c; p 46

10. SUBJECT OF AMENDMENT:
Services: Dental Services

Minnesota (02-015)
Approved: 09/20/02
Effective: 05/28/02

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED: 06/24/02

16. RETURN TO:
Stephanie Schwartz
Minnesota Department of Human Services
Federal Relations Unit
444 Lafayette Rd. No.
St. Paul, MN 55155-3852

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6-25-02

18. DATE APPROVED: 9/20/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: May 28, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
JUN 25 2002
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

10. Dental services.

A. Coverage of dental services is limited to medically necessary services within the scope of practice of a dentist, with ~~the limitations~~ examples listed below. ~~Except for root canal treatment, limitations do not apply to medically necessary dental services under EPSDT.~~ Services and procedures requiring prior authorization are published in the *State Register*.

~~Service~~	~~Limitation~~
• Oral hygiene instruction	~~One time only.~~
• Reline or rebase of a removable denture	~~One every three years.~~
• ~~Topical~~ Fluoride treatment	~~One every six months for a recipient 16 years of age or younger unless prior authorization is obtained.~~
• Full mouth or panoramic x-ray	~~One every three years, for a recipient eight years of age or older, unless prior authorization is obtained~~.
• Full mouth debridment	
• Fillings	
• ~~Dental examination~~ Oral evaluation	~~One every six months unless an emergency requires medically necessary dental service.~~
• Prophylaxis	~~One every six months.~~

10. Dental services. (continued.)

• Bitewing series	~~One of no more than four x-rays and no more than six periapical x-rays every 12 months unless a bitewing or periapical x-ray is medically necessary because of an emergency.~~
• Palliative treatment	~~For an emergency root canal problem.~~
• Sealant application	~~One application to permanent first and second molars only and one reapplication to permanent first and second molars five years after the first application only for recipients 16 years of age and under.~~
• Removable ~~prostheses (includes instructions in the use and care of the prostheses and any adjustment necessary for proper fit during the first six months)~~ partial and full dentures	~~Requires prior authorization.~~
• Root canal treatment	~~One root canal therapy per tooth.~~
• Inpatient hospitalization for dental services, subject to utilization review procedures	~~Requires prior authorization.~~
• Surgical services~~, except emergencies, alveolectomies,~~ and ~~routine tooth~~ extractions	~~Requires prior authorization.~~

10. Dental services. (continued.)

- ~~Periodontics~~ Periodontal scaling and root planning, if: ~~Requires prior authorization.~~

  a) evidence of bone loss must be present on current radiographs to support the diagnosis of periodontis;

  b) there is a current periodontal charting with six point and mobility noted, including the presence of pathology and periodontal prognosis;

  c) the pocket depths must be greater than four millimeters; and

  d) classification of the periodontology case type is in accordance with documentation established by the American Academy of Periodontology.

- Orthodontics~~, except for space maintainers for second deciduous molars~~ treatment, if: ~~Requires prior authorization.~~

  a) there is a disfigurement of the patient's face, including protrusion of upper or lower jaws or teeth;
  b) there is spacing between adjacent teeth that interferes with the biting function;
  c) there is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the person bites;
  d) positioning of jaws or teeth impairs chewing or biting function; or
  e) based on a comparable assessment of a) through d), there is an overall orthodontic problem that interferes with the biting function.

- Space maintainers

10. Dental services. (continued.)

- Crowns, if made of prefabricated stainless steel, prefabricated resin, or laboratory resin. An exception applies for a crown fitted in conjunction with a fixed bridge or a dental implant.

- Dental implants, if:

  a) there is bone and tooth loss that compromises chewing or breathing; and
  b) a complete treatment plan, including prosthesis and all related services, is approved before the start of treatment.

- Removal of impacted teeth~~, unless it is an emergency~~ ~~Requires prior authorization.~~

- Fixed bridges ~~When cost effective for recipients who cannot use removable dentures because of their medical condition, requires prior authorization. To be considered for prior authorization, the recipient must have less than four upper and four lower back teeth that meet and are in biting function unless the missing teeth are permanent teeth and the recipient has only bicuspid occlusion. A fixed bridge will be considered as a replacement for one or more front teeth.~~

10. Dental services. (continued.)

~~Orthodontic treatment, except space maintainers.~~	~~Requires prior authorization.~~
~~Services in excess of those listed above~~	~~Requires prior authorization.~~

- Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), once every three years per recipient, unless the prosthesis:

  a) was misplaced, stolen, or damaged due to circumstances beyond the recipient's control; or

  b) cannot be modified or altered to meet the recipient's dental needs.

  A cast metal removable prosthesis is covered if:

  a) the crown to root ratio is better than 1:1;

  b) the surrounding abutment teeth and the remaining teeth do not have extensive tooth decay; and

  c) the abutment teeth do not have large restorations or stainless steel crowns.

B. The following dental services are not eligible for payment:

~~1)~~ ~~Full mouth of panoramic x-rays for a recipient under eight years of age unless prior authorized, or in the case of an emergency;~~

~~2)~~ • ~~Base or pulp~~ Pulp caps~~, direct or indirect;~~

~~3)~~ • Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure~~;~~

~~4)~~ • Hygiene aids, including toothbrushes~~;~~

~~5)~~ • Medication dispensed by a dentist that a recipient is able to obtain from a pharmacy~~;~~

~~6)~~ • Acid etch for a restoration that is billed as a separate procedure~~;~~

10. Dental services. (continued.)

~~7)~~ • ~~Periapical x-rays, if done at the same time as a panoramic or full mouth x-ray survey unless prior authorization is obtained;~~

~~8)~~ • Prosthesis cleaning~~;~~

~~9)~~ • ~~Unilateral~~ Removable unilateral partial ~~prosthesis involving posterior teeth~~ denture that is a one-piece cast metal including clasps and teeth~~;~~

~~10)~~ • Replacement of a denture when a reline or rebase would correct the problem~~;~~

~~11)~~ • Duplicate x-rays;

~~12)~~ • ~~Crowns and bridges~~ Fixed partial denture or fixed bridge, unless it is medically necessary and cost-effective for ~~the~~ a recipient ~~has a documented medical condition that prohibits the use of~~ who cannot use a removable prostheses~~;~~ ~~and~~

~~13)~~ • Gold restoration or inlay, including cast nonprecious and semiprecious metals~~.~~

• Dental services for cosmetic or aesthetic purposes

C. Critical access dental providers receive an increased payment pursuant to Attachment 4.19-B, item 10. There are two types of critical access dental providers:

1) those whose combined claim and estimated encounter claim payments for all Minnesota Health Care Programs (Medical Assistance, General Assistance Medical Care and MinnesotaCare) were at least $50,000 for service dates of April 1, 2000 through March 31, 2001; or

2) those providing dental services in counties for which dental services are carved out of managed care and are paid fee-for-service. These providers must increase the number of recipient visits by at least 10 percent over the last three-month quarter for which complete data on the number of recipient visits exists.

STATE: MINNESOTA
Effective: May 28, 2002
TN: 02-15
Approved: SEP 20 2002
Supersedes: 00-11

ATTACHMENT 3.1-A
Page 47

12.b. Dentures.

- ~~Purchase~~ Initial placement or replacement of removable dentures is limited to one time every ~~five~~ three years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified ~~if a client is missing teeth necessary to fit~~ or ~~anchor~~ altered to meet the ~~dentures~~ client's dental needs.

- Replacement of dentures less than ~~five~~ three years old requires prior authorization.

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.